Kansas Drug Utilization Review Newsletter

Health Information Designs, LLC *4th Quarter 2018*

Welcome to the Quarterly edition of the "Kansas Drug Utilization Review Newsletter," published by Health Information Designs, LLC (HID). This newsletter is part of a continuing effort to keep the Medicaid provider community informed of important changes in the Kansas Medical Assistance Program (KMAP).

Helpful Web Sites

KMAP Web Site
https://www.kmap-state-ks.us/

KDHE-DHCF Web Site
http://www.kdheks.gov/hcf/

KanCare Web Site
http://www.kancare.ks.gov/

Fee-For-Service (FFS) Helpful Numbers

Provider Customer Service (Provider Use Only)
1-800-933-6593

Beneficiary Customer Service
1-800-766-9012

KMAP PA Help Desk
1-800-285-4978

In This Issue:

Overview of Diabetes Mellitus and the ADA Standards of Care

Overview of Diabetes Mellitus

Diabetes mellitus (DM) is a group of metabolic disorders characterized by high blood glucose (BG) levels over a prolonged period of time due to the bodies inability to absorb glucose. The two most common causes for this are found in type 1 DM (DM1) which results from the pancreas' failure to produce enough insulin due to loss of beta cells, and type 2 DM (DM2) which is a condition in which cells fail to respond to insulin properly. Approximately 30 million Americans have some form of DM, with ~95% of cases being DM2. Additionally, 84 million Americans 18 and older have prediabetes, a condition where BG levels are higher than normal, but not at the level of DM. If left untreated, DM can cause many complications including cardiovascular disease, stroke, chronic kidney disease, foot infection, and retinopathy.

Due their differing pathophysiology, the drug treatments of DM1 are primarily limited to insulin products., whereas treatment options of DM2 include multiple medication classes, targeting multiple different pathways, all with the primary outcome of reducing BG levels. These classes include insulins; the biguanide metformin; insulin sensitizing medications such as thiazolidinediones (e.g. Actos); promoters of insulin secretion such as sulfonylureas (e.g. Amaryl), meglitinides (e.g. Prandin), dipeptidyl peptidase-4 (DPP-4) inhibitors (e.g. Januvia), and glucagon-like peptide (GLP) agonists (e.g. Victoza); and sodium/glucose cotransporter 2 (SGLT2) inhibitors (e.g. Invokana) that promote glucose excretion by blocking glucose re-uptake in the kidneys. Guideline recommendations for initial drug treatment of DM2 recommend metformin as a first line agent, with agents of the other classes used in scenarios when a patient is unable to take metformin, or as add-on agents for patients with uncontrolled DM2. The choice of which agent to use should always be made based on patient-specific characteristics (e.g. comorbidities, tolerability, etc.), as well as current drug safety and efficacy data.

The American Diabetes Association's Standards of Medical Care in Diabetes

The American Diabetes Association (ADA) has long maintained a series of recommendations for managing patients with DM titled the Standards of Medical Care in Diabetes (Standards of Care). The recommendations in the Standards of Care are produced by a multidisciplinary team of experts in the field of DM, utilizing the most current data available. They are revised on an annual basis to ensure the recommendations remain up-to date as new information comes out.

For your convenience, an overview of some notable updates to the Standards of Care regarding management of patient with prediabetes and diabetes is provided on the following pages. Please be advised that this overview does not include all of the ADA's recommendations. To see the full recommendations, please visit the ADA's website, available at www.diabetes.org.

Highlighted Updates to the ADA's Standards of Care

Recommendations for Pediatric Patients

There were numerous additions and updates to recommendations throughout the Standards of Care regarding the management of diabetes in pediatric patients, including changes to recommendations regarding screening for prediabetes and celiac disease, the removal of a recommendation regarding estimating glomerular filtration rate, and a substantial expansion of a section focused on diabetes mellitus in pediatric patients. This expansion contains numerous newly added recommendations regarding monitoring, pharmacological treatment, and lifestyle changes in pediatric patients with diabetes. Select notable recommendations regarding blood glucose (BG) monitoring and pharmacological treatment are summarized below.

Pediatric Patients with Type 2 Diabetes Mellitus

- Pharmacologic therapy should be initiated at diagnosis of DM2.
    - For asymptomatic patients with an A1C <8.5%, metformin is the initial treatment of choice.
        - If A1C target is no longer met with metformin monotherapy, or if contraindications or intolerable side effects of metformin develop, basal insulin therapy should be initiated.
    - Symptomatic patients with marked hyperglycemia, treat initially with basal insulin while metformin is initiated and titrated to maximally tolerated dose to achieve hemoglobin A1c (A1c) goal.
        - Basal insulin can be tapered over 2–6 weeks by decreasing the insulin dose by 10–30% every few days in those patients who are meeting glucose targets.
    - Use of medications not approved by the U.S. Food and Drug Administration for youth with type 2 diabetes is not recommended outside of research trials.

Pediatric Patients with Type 1 Diabetes Mellitus

- Patients with DM1 should be treated with intensive insulin regimens.
- All pediatric patients with DM1 should self-monitor blood glucose (BG) levels multiple times daily and continuous BG monitoring should be considered in these patients as an additional tool to help improve glycemic control.
- Automated insulin delivery systems should be considered for pediatric patients with DM1 as they improve glycemic control and reduce hypoglycemia in these patients.

General Recommendations for Older Adult Patients

There are three newly included general recommendations to the Standards of Care regarding pharmacotherapy that were added to highlight the importance of individualizing pharmacologic therapy in older adults, which include the following:

- In older adults at increased risk of hypoglycemia, medication classes with lower risk of hypoglycemia are preferred.
- To reduce the risk of hypoglycemia, complex medication regimens should be simplified when possible to do so while remaining within the patient's individualized A1C target.
- Overtreatment of diabetes is common in older adults and should be avoided.

Highlighted Updates to the ADA's Standards of Care

Updated Recommendations for Adults with DM

- Patients with Comorbid Hypertension (HTN):
  - A recommendation was added stating that all patients with DM and HTN should conduct home blood pressure monitoring to improve medication-taking behavior.
  - The guidelines introduced a new figure (figure 9.1) to illustrate the recommended HTN treatment approach for adults with DM, as well as a new table (table 9.1) that summarizes studies of intensive versus standard hypertension treatment strategies.
  - A recommendation was added to consider mineralocorticoid receptor antagonist therapy in patients with resistant hypertension.
- Patients with Comorbid Atherosclerotic Cardiovascular Disease (ASCVD)
  - The lipid management recommendations were modified to now stratify risk based on 2 categories: patients age <40 vs ≥40 years of age, and those with vs. without documented ASCVD.
    - Patients with documented ASCVD are recommended to receive a high intensity statin.
    - Patients without documented ASCVD, ≥40 years of age are recommended to receive a moderate intensity statin.
    - Patients without documented ASCVD, <40 years of age are recommended to receive a moderate intensity statin or no statin therapy.
  - The recommendation regarding the use of other lipid-lowering agents was modified to recommend considering additional, non-statin, lipid-lowering therapies for patients with DM and ASCVD who have LDL cholesterol ≥70 mg/dL despite maximally tolerated statin dose.

Kansas Medicaid Coverage of Diabetic Agents

Kansas Medicaid has at least one medication from each class indicated to treat DM1 and DM2 available as a preferred agent (does not require prior authorization). These agents include the following:

- **Insulin**: Humalog vials, Humalog Mix vials, Humulin N vials, Humulin R vials, Humulin 70/30 vials, Novolin N vials, Novolin R vials, Novolin 70/30 FlexPen, Novolin 70/30 vials, Novolog, Novolog Mix, Velosulin BR vials, Lantus, and Levemir
- **Biguanides**: Glucophage (metformin) and Glucophage XP (metformin ER)
- **Sulfonylureas**: Amaryl (glimepiride), DiaBeta (glyburide), Glucotrol (glipizide), Glocovance (glyburide/metformin), Glynase PresTab (glyburide), and Micronase (glyburide)
- **Meglitinides**: Prandin (repaglinide)
- **GLP-1 Agonists**: Bydureon (exenatide ER), Byetta (exenatide, and Victoza (liraglutide)
- **DPP-4 Inhibitors**: Januvia (sitagliptin) and Onglyza (saxagliptin)
- **SGLT-2 Inhibitors**: Invokana (canagliflozin)
- **Combination Products**: Soliqua (insulin glargine/lixisenatide), Invokamet (canagliflozin/metformin), Invokamet XR (canagliflozin/metformin ER), Glyxambi (empagliflozin/linagliptan), , Janumet (sitagliptin/metformin), Janumet XR (sitagliptin/metformin ER), and Kombiglyze (saxagliptin/metformin)

For information regarding Kansas Medicaid's coverage rules for specific agents indicated for the treatment of DM, please see the Preferred Drug List and Diabetic Agents Class-Specific Clinical Criteria, both of which can be found through the Pharmacy page of the KanCare and Medicaid website, located at www.kdheks.gov/hcf/pharmacy.

References

1) Centers for Disease Control and Prevention. National diabetes statistics report, 2017. Atlanta, GA: Centers for Disease Control and Prevention. 2017.
2) American Diabetes Association. Standards of Medical Care in Diabetes-2018. Diabetes Care 2018; 41:S1-156.
3) Summary of Revisions: Standards of Medical Care in Diabetes-2018. Diabetes Care 2018; 41:S4.

Generic Medications

Recently Approved Generic Drugs:

September 2018	October 2018	November 2018
Atripla (efavirenz/emtricitabine/ tenofovir) Brillinta (ticagrelor) Albenza (albendazole)	Zytiga (abiraterone) Onfi (clobazam) Suprax (cefixime)	Amicar (aminocaproic acid) Butrans Transdermal (buprenorphine) Finacea (azelaic acid gel) Mitigare (colchicine capsules) Roxicet (oxycodone/APAP)

Upcoming Generic Drugs:

Generic Name	Brand Name	Anticipated Launch
Imiquimod	Zyclara cream	January 2019
Minocycline HCl	Solodyn	February 2019
Ranolazine	Ranexa	February 2019
Aliskiren HCl	Tekturna	March 2019
Fosaprepitant	Emend	March 2019

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